COLLABORATIVE ASSESSMENT PROGRAM (CAP)
COMMONWEALTH OF MASSACHUSETTS
Request for Assessment of Risk of Residential Placement

PARENT/GUARDIAN INFORMATION (If more than one parent, complete for primary contact person)

Name of parent/guardian:		
Address:		
City:		Zip:
Telephone: Home: ( )	Work: ( )	
Date of Birth:	Sex:	Marital Status:
Social Security #:	Family's Gross Monthly Income:	
Employer(s)/Source(s) of Income		
Ethnicity:	Preferred Language:	

YOUTH FOR WHOM YOU ARE REQUESTING SERVICES:

Name of youth:			
D.O.B.	Sex	Social Security #	
Currently residing at home?	Yes	No	
If residing in hospital or crisis placement:	Date admitted:		
Name of hospital/program:		Tel. #	
Attending MD:		Social Worker:	
Health Insurance Provider(s)		Policy#	
School:			
Special ed plan:			
Diagnosis (if you know it):			
Medications:			

Have you ever received services from DSS? YES NO

If YES, when & where?

What services?

Have you ever received services from DMH? YES NO

If YES, when & where?

What services?

Have you ever received services from another state agency (which, when)?

On a separate piece of paper please answer these 2 questions:

What is it about your situation or your child that leads you to make this request?

What services do you think would help?

PLEASE SEE REVERSE OF THIS FORM

Please have referring person complete this section:

	YES	NO
1. Child/ adolescent's IQ is below 70.	____	____
2. Child/ adolescent has an Autism Spectrum Disorder (Autism, Pervasive Developmental Disorder [PDD], or Asperger's)	____	____
3. Child/ adolescent's substance abuse is the primary issue.	____	____
4. Child/ adolescent's primary difficulties arise from brain damage, organic disorder, head injury or medical problem.	____	____
5. Child/ adolescent is conduct-disordered or has a delinquent history not closely tied to serious emotional disturbances	____	____
6. There are protective issues or major parenting issues unrelated to child's special needs, such as parental substance abuse or mental illness.	____	____
7. Child/ adolescent has a mental illness or serious emotional disturbance.	____	____

****PLEASE NOTE:** If referral source is a hospital or other treatment program, admission and treatment summaries, as well as results of any testing, **must accompany this referral form.**

Referring Person: **Tel. #:**

Agency: **Date:**

For parent/ guardian:
I/We understand that the Collaborative Assessment Program is a program of the Dept. of Mental Health (DMH) and the Dept. of Social Services (DSS) and that CAP may share information with these agencies. Please sign the attached information release form.

Signed:_____**Date**_____
(Parent/Guardian)

All referrals should first be screened by phone, then mail or FAX this form:

Western MA* Allison Zolotor-Langone, Director (413) 452-3438. FAX (413) 781-4482 CAP, 1537 Main Street, Springfield, MA 01103	**Central MA*** Beth Lynch, Director (508) 929-2195. FAX (508) 754-0420 CAP, 340 Main St., Suite 720, Worcester, MA 01608
Northeast MA* Pamela Gray, Director (978) 557-2706. FAX (978) 557-9231 CAP, 15 Union St., 2nd Fl., Lawrence, MA 01840	**Boston*** Meredith Leigh, Director (617) 822-4864. FAX (617) 822-4849 CAP, 50B Park Street, Dorchester, MA 02122
Metropolitan (Suburban Boston)* Charles Sullivan, Director (781) 641-8208. FAX (781) 648-6909 CAP, 30 Mystic St., Arlington, MA 02174	**Southeast MA*** Marjorie Waite, Director (508) 946-5548. FAX (508) 947-8824 CAP, 109 Rhode Island Rd., Lakeville, MA 02347

***See list of towns if you are unsure which office covers your town.**